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Original Articles

*INSULIN AND THE MENTAL STATE OF DEPRESSION—A PRELIMINARY REPORT

D. M. COWIE, M. D., J. P. PARSONS, M. D.,
T. RAPHAEL, M. D.
ANN ARBOR, MICHIGAN

The remarkable clearing up of the depression in diabetes on insulin treatment suggested to us quite early in our work with insulin the advisability of making observations on the effect of insulin in states of depression. It is well known that in manic depressive depression the patient may pass back and forth from a state of depression to one of excitation. Raphael and Parsons have shown that a prolonged glucose utilization curve is characteristic of the depressive stage and that the curve goes below normal as the patient recovers or passes into the excitation stage.

The slowness with which glucose is utilized by depressives it would seem, may be due to one or two things—(1) A failure of the pancreas to pour out enough insulin—a disfunction of the pancreas, or, (2) an increase of substances in the body which antagonizes the action of insulin—perhaps an imbalande of these opposing factors, all of which are probably elaborated by the mechanism of internal secretion.

We have determined the folllowing points: The prolonged glucose utilization curve of manic depressive depression is easily made to conform to the normal curve by the administration of a certain amount of insulin. This amount of insulin may be a measure of the disfunction of the pancreas or of the activity of the opposing factors.

It is well known that epinephrin, when injected subcutaneously, causes an increase in blood sugar. Macleod, Banting and their coworkers and Cowie and Parsons have demonstrated that the effect of epinephrin may be overcome by insulin, that is, the hyperglycaemia and the mobilization of glycogen.

We have a number of cases of depression of this type under insulin treatment. The results of this work will be recorded later.

*From the Department of Pediatrics and Infectious Diseases and the Department of Psychiatry, University of Michigan.

*THE SURGICAL TREATMENT OF THYROID DISEASES

H. K. SHAWAN, M. D.
DETROIT, MICH.

The thyroid, because of widely diverse changes displayed under varied conditions, has become the best understood of the endocrine glands. Active interest has been stimulated because of its prominent position, evident differences in size and form, numerous pathological pictures, and frequent examples of both over and under activity with their accompanying alteration of the body metabolism. While much progress has been made, the cause of certain types of goitre, the frequency in certain regions, the individual predisposition to adenoma, the etiology of malignancy, and the activating factors in toxicity are problems still incompletely solved.

Medical or surgical treatment is indicated in thyroid diseases to secure relief from size, pressure, deformity, pain, over or under-activity, or to anticipate, cure or check toxic symptoms. In arriving at proper conclusions, certain factors must be taken into consideration; the type of disease present, the duration of the condition, the stage attained, the period of life, the damage produced or accumulated, as well as the result already obtained or expected from any given method. Improper stress and disregard for some of these standards of clinical measurement are responsible for differences of opinion. Taken together, they form a valuable basis upon which to make our clinical diagnosis, estimate the patient's available reserve, advise treatment and formulate a prognosis. Without careful balanced determination of these elements, accurate judgment of the case will not prevail nor can the best treatment be selected for the individual in question.

In considering the operative indications, thyroid diseases are conveniently divided into atrophy and hypertrophy.

1. Atrophy is found in the forms of senile

atrophy, myxoedema and cretinism. Senile atrophy causes few pronounced symptoms and being but a phase in advanced life, rarely requires or responds to any treatment. Myxoedema and cretinism act best and occasionally quite noticeably to medical management. The surgical treatment of hypothyroidism has been very unsatisfactory to date. Possibly the results in iso-grafting human thyroid tissue might be improved by applying the principle of blood grouping as suggested by Dr. Goodman.

2. By hypertrophy we refer to goitre. For the purposes of surgical consideration, enlargements of the thyroid may be subdivided into inflammatory, malignant, simple goitre and toxic goitre. The many mixed pathological types and the different physiological manifestations tend to increase the complexity of goitre nomenclature. Hence, it seems advisable to confine the discussion of goitre to the more simple classification given above.

Inflammatory changes in the thyroid gland may be either acute or chronic. Fortunately, acute inflammations are rare. Acute thyroiditis may be confused with malignancy because of the firm consistency in its early stage. Exquisite tenderness stands out prominently among the cardinal findings. The indications are for hot applications to the gland. Once abscess formation is detected, early incision with the least trauma and adequate drainage is used. Resection and lobectomy are to be condemned, not only because of their futility, but because new avenues of infection are opened up, permitting gravitation into the unprepared and dangerous area of the mediastinum. Chronic thyroiditis requires elimination of the cause, followed by general hygienic treatment. Partial resection of a goitre enlarged by chronic inflammation is indicated, especially if symptoms of hyperthyroidism are present. Care must be exercised in operating upon thyroids which have been extensively infected in the past, and an adequate amount of gland tissue must be preserved since the inflammation may have impaired the gland function. Tuberculosis is manifested in the thyroid as small, hard nodules. The infected parts of the gland may require excision, but general treatment is always indicated. Gummata may be removed to relieve pressure, although the treatment is essentially medical. Opinion is often sought by thin, under-nourished, anaemic, nervous women between the ages of 30 and 45, who present a flat, woody, strap-like, moderate enlargement of the isthmus. The lateral lobes may be barely perceptible, but are quite firm. Examination will often reveal focal infections elsewhere. Operative treatment of this sclerosed type of gland gives no relief, the indications being eradication of the source of infection plus a hygienic regime.

Malignant tumors of the thyroid gland are more frequent than usually supposed. Two types of carcinomata are recognized: the first is relatively benign and remains local to the thyroid for a long time; the second is actively malignant and metastasizes early and rapidly. Clinically, they present irregular, hard tumors which have suddenly started to grow in long quiescent goitres of individuals usually past middle life. They may simulate organized hemorrhage into an adenoma. Frequently they are accompanied by the toxic symptoms of hyperthyroidism. Exact diagnosis usually entails considerable difficulty in the early stages. In order that better results may be obtained, it is advisable to remove all firm growths before they have progressed to a point where the determination is definite. It is accepted as axiomatic that when a positive diagnosis of malignancy of the thyroid is made, the case is incurable. In case of doubt, we are justified in operating to make a diagnosis. Benign tumors may occasionally be removed on these grounds, but such procedure is justifiable because they never can be more benign as time goes on and frequently they do become hopelessly malignant. Dr. Allen Graham, from a study of a large group of specimens, concludes that more than 90 per cent of cancer of the thyroid develops on fetal adenomata which are of congenital origin and have made their presence known for years. The prophylactic removal of all thyroid nodules is self evident. Sarcomata of the thyroid are relatively rare. They usually appear in younger individuals, the growth is rapid, the tumor hard, smooth, rounded and usually unilateral at the start.

Simple goitre comprises all quiescent enlargements of the thyroid. They are colloid goitre, cystic goitre, and adenomatous goitre. In common are two factors, presence of tumor and lack of over-activity.

Simple colloid goitre is variously designated as atoxic, endemic, or functional. Appearing usually during adolescence and during pregnancy, it seems to serve a functional demand. Having fulfilled its purpose the enlargement usually returns to normal, although it often persists and continues to enlarge. It rarely appears late in middle life. Examination of the thyroid reveals a uniform, symmetric enlargement of the gland involving isthmus as well as the lateral lobes. On palpation a characteristic, smooth, moderately soft, somewhat granular consistency is made out. The microscopical picture is that of irregular shaped, enlarged, dilated acini, containing well staining colloid material. The interstitial tissue is moderate in amount, while the lining epithelium is low, flat, cubodal in type.

Operation in the adolescent colloid type is rarely indicated. Often it subsides either with

or without treatment. It is in adolescent goitre that Marine and Kimball obtained striking results, on a large scale, along preventative lines, by administration of minute quantities of iodine. Furthermore, the gravid woman should receive a similar medication to prevent the physiological enlargement of the thyroid during pregnancy and to avoid atypical thyroid activity in the offspring. Where a failure to obtain disappearance of a colloid goitre occurs after the use of iodine, one may be reasonably sure that one is dealing with an adenomatous type rather than with a pure colloid. Some warning must be given as to the reckless use of iodine and of thyroid extract in large doses and over long periods. Severe toxic symptoms have often occurred from excessive indulgence. When used, both drugs should be given with the greatest care. Owing to the popularity and to the ease with which thyroid extract can be obtained without prescription, numerous unfortunate results from self-medication have occurred. Measured subnormal metabolism is the one permissible guide to employing this dangerous drug. While the treatment of simple colloid goitre, especially of the adolescent type is mainly medical, extreme size with obstruction or impairment of respiration definitely traceable to the growth is an indication for surgery.

The second type of simple goitre is the cystic. These cysts are usually the end results of hemorrhage into some portion of the thyroid gland. Rarely is the contained material of a clear fluid variety. Rather are they made up of colloid showing various degrees of an atypical thyroid structure. They are usually unilateral or central, and the diagnosis is easily arrived at. The treatment of cysts of the thyroid is surgical because of their size, pressure and unsightly appearance.

The third type of simple goitre is the adenomatous. This is by far the most common type of goitre encountered among adults in the Great Lakes region. In their origin they are either congenital or they may arise in a manner similar to cysts. Clinically, in the simple types of adenomatous goitre, a more or less irregular tumor studded with nodules is presented. On palpation they vary from extreme hardness and firmness to softness and semi-fluctuation. They may be small or extensive and are frequently multiple. They are prone to a variety of degenerations. In their growths, large adenomata tend to thin out the normal thyroid tissue over an extensive circumference of tumor, so to prevent impairment of the remaining healthy gland, definite indications exist for their removal. Under medical or radiological treatment no results are obtained in simple adenomatous goitre other than to magnify the tumors by shrinking the surrounding normal gland tissue. Unfavorable reactions to non-surgical treatment are frequently met with in elderly persons having adenomata of long standing. Adenomata may be present in goitres of young people, but only when they are single or at the most, few in number, is operative treatment indicated. If, however, multiple adenomatosis is suspected, the results will be more satisfactory if the operation is delayed a few years until the patient is older and the position, number and size of the tumors in the gland are better demarcated. While adenomata in adolescent individuals show no improvement with time or medical treatment, still results of early surgery on them may prove disappointing in that minute encapsulated tumors, easily overlooked at the time of operation, start to grow and in a few years are productive of the so-called recurrent goitre. The most common type of substernal goitre is the adenomatous. Because they are frequently productive of interference with respiration in this position, the indication is for early operative removal. While typical symptoms of toxicity may develop with substernal goitre, there is one type which inclines more to chronic obstruction of the respiration rather than to true hyperthyroidism. The eyes exhibit an anxiety rather than the fear expression of exophthalmic goitre. The pulse usually is of average rate. Removal of the obstructing substernal goitre takes away the cause of their anxiety and they rapidly return to normal.

It is established that surgery is the only satisfactory treatment of all types of adenoma in the adult. Their very structure excludes cure by any but operative means. This type of goitre is responsible for nearly one quarter of all thyroid intoxications, precedes 90 per cent of all malignant goitres, is the cause of the majority of obstructions and is always a cosmetic regret. In view of these potentialities, it is best to remove all adenomata from prophylactic, curative or cosmetic standpoints. Since the operative course and results are so satisfactory it is advisable to excise these tumors early rather than to await the development of undesirable symptoms. Frequently but one or two adenomata require excision, but where numerous small tumors are present considerable technical care is necessary in order not to leave minute nodules, which may result in imperfect results or recurrence in the future.

Toxic Goitre includes exophthalmic goitre and toxic adenoma, as well as such mono-symptomatic forms as goitre heart, nervous prostration and the like. In passing, the occurrence of toxic symptoms with inflammation and with malignancy of the thyroid may be mentioned. While the etiology is not entirely known, toxic goitre is a disease of the thyroid gland and the term hyperthyroidism serves to cover the entire group. It may be acute, or slow and insidi-

ous in the initial appearance, and if proper treatment is not instituted early, is characterized by recurrences, each succeeding attack leaving the victim worse off than before. Toxic goitre may present tachycardia, tremor, nervousness, loss in weight, muscular weakness, high pulse pressure, gastro-intestinal upsets, and mental and physical restlessness. In spite of the fact that the two outstanding types of toxic goitre have many symptoms in common and probably have a common origin, they may be readily differentiated from one another. Hyperthyroidism with adenoma may be distinguished from hyperthyroidism with cellular hyperplasia by history of enlargement over a longer period, by the onset of toxic symptoms occurring long after the presence of the goitre was known, by the rarity of exophthalmos, and finally by the nodular appearance and irregular consistency contrasted with the firm, symmetrical condition present in exophthalmic goitre. Furthermore, the tremor in toxic adenoma may be either fine or coarse and the pulse rate may fluctuate from normal to rapid irregularity, whereas in exophthalmic goitre the tremor is fine and the tachycardia is steady and continuous until late. Both types show an increase in the metabolic rate, which may be about equal. Chemical examination of adenomatous tissue shows a variation in the iodine content in contrast to the uniform low amount of iodine in the true hyperplastic gland. In later life and especially during the menopause, adenomata are likely to changes with toxic symptoms. In spite of the fact that for all practical diagnostic and therapeutic purposes the various types of increased thyroid activity should be considered as different manifestations of the same disease. a differentiation in symptomatology between the two outstanding types is herein given. This is done for the simple reason that outspoken adenomata are carelessly ignored by sectarian therapeutists in their zeal to apply proven ineffective non-surgical means. It is universally accepted, we repeat, that surgery offers the only cure for adenoma of all types including adenoma with hyperthyroidism. In hyperthyroidism accompanied by hypertrophy and hyperplasia of the secreting cellular elements. (exophthalmic goitre), the gland is firm. smooth. symmetrical. occasionally tender. and may not be greatly enlarged. Increased blood supply is evidenced by compressability. marked pulsation of the gland. and of the vessels supplying it. as well as by the presence of a hum and bruit. Microscopically, the colloid. as well as the interstitial tissue. appears relatively decreased due to overgrowth and infoldings of the epithelial cells.

According to the severity of the signs and symptoms, various types of exophthalmic goitre from the mild to the very severe are made out. While the early stages are occasionally controlled by suitable medical treatment, constant watch and care must be exercised to avoid a sudden outburst of rapidly progressing acute hyperthroidism with loss of opportunity. Medical treatment includes not only drugs, rest in bed and avoidance of strain, but it also requires that all forms of irritation and focal infection be eradicated. From the standpoint of cure of exophthalmic goitre, radiotherapy is uncertain and unsatisfactory at the present time. Acute exacerbation of symptoms, temporary improvements requiring repetition of treatment and severe burns, often appearing six months to two years after exposure, are seen. Extensive degenerations elsewhere in the body and occasional fatalities have occurred through protracted medical and radiological treatment. Consequently, considerable responsibility is involved in advising or prolonging non-surgcal treatment in hyperthyroidism. It is increasingly evident that a definite diagnosis of exophthalmic goitre demands early surgical intervention.

At the present time surgery offers the best results in hyperthyroidism. Results from many clinics indicate that operative interference gives a higher percentage of cures than any other measure, while attended by a minimum mortality rate, and that it secures quickest recovery, with the least impairment to the future health of the patient. This is especially true when operation is performed in the stage before extensive damage has been done to other tissues of the body. The best treatment combines the medical both before and after the all-important link of surgery. The pre-operative preparation is of fundamental importance and is essentially medical. During this period everything is done to obtain physiological rest, to relieve the nervousness, and to increase elimination. Large quantities of water and saline are administered to carry away waste matter from the tissues. Digitalis is given not only to improve the heart, but to assist the circulation in this elimnation. Bromides, paraldehyde and morphine are given to induce quiet. Cathartics and intestinal antiseptcs are employed. Suggestion, and above all, reassurance are of the greatest value. With such forced treatment it is frequently possible to prepare a patient for operation in a short time. Subtotal bilateral resection has been productive of the most permanent results and is the operation of choice. The return to normal is delayed or the final results less complete when insufficient amount of secreting gland tissue is removed. Where the disease is far advanced and the patient is "physiologically wrecked" as shown by edema, damaged myocardium, and other destructive changes, a complete cure cannot be predicted, but a careful proper operative treatment will

check the further progress of the disease even in this stage.

In regard to the actual operative technique, a few remarks concerning the general handling of all types of goitre will be made. The most satisfactory incision is a transverse one placed directly along the skin planes and carried without beveling directly through the skin and platysma. This should never be made too low as all neck incisions slide downwards and the firm manubrium beneath tends to broaden the resultant scar. The skin and platysma flap is then widely undermined in all directions. The pre-glandular muscles are split vertically down to the gland and in the majority of instances, by gentle retraction, the operation is continued without dividing these muscles transversely. When necessary, however, we do not hesitate to cut the pre-glandular muscles in order to obtain greater exposure. The post-operative progress is more comfortable when this procedure is dispensed with. In dealing with the gland, it is often much easier to split the isthmus vertically to the trachea and then do a subtotal bilateral symmetrical resection, after catching all visible blood vessels about the circumference of the intended incision through the gland. Blood supply is controlled and cut edges of the gland approximated with secure running button hole sutures of fine plain catgut, tieing with each stitch. A small portion of gland tissue adjacent to the posterior capsule, amply protecting the neighborhood of the parathyroids and recurrent nerve, is preserved on each side. A thin mat of areolar tissue is left covering the trachea to prevent post-operative irritation and hoarseness due to too close extratracheal dissection. Any remains of the thyroglossal duct is removed in order to avoid post-operative hypertrophy of this structure, which may simulate an exaggerated "Adam's apple." The pre-glandular muscles and the cut edges of platysma are then approximated in their original position with fine plain catgut. Omission of accurate platysma co-aptation has resulted in disfiguring scars. Clips are placed in the skin. Drainage is used only where much gland tissue has been incised. A secure dressing is applied with adhesive straps.

In the severe types of toxicity the operative treatment is applied along the more safe lines of the multiple stage operation, each step being graded to the condition of the patient at a given time. Preceded by morphine or heroin, the operation or operations are performed under light nitrous oxide and local anaesthesia. To rely wholly on one or the other frequently is insufficient protection against psychic shock and post-operative hyperthyroidism. Severe cases are submitted to preliminary ligation of the superior thyroid artery, either singly or doubly, while in their bed. We feel that considerable improvement is obtained by this procedure and that it affords an excellent basis upon which to determine the patient's resistance and upon which to make a decision as to what and when subsequent surgery is possible. Usually a delay of four week after ligation is sufficient before attempting the resection of the gland. Again in the severe types this is done preferably under analgesia and often without the patient's knowledge.

Post-operatively the head of the bed is elevated to eliminate gravity throbbing. Fluids are forced as rapidly as they are absorbed. Morphine is used as indicated, especially during the first 24 hours. Ice caps are applied to the head and the heart. Frequent sponging of the body and extremities with cold water is used to control restlessness. Advanced cases are greatly benefited by transfusion of blood. Actual packing in ice is indicated when there is severe post-operative fever. For some time, we have had considerable success in preventing severe post-operative hyperthyroidism by administering five grains of thyroid extract or ten drops of the syrup of the iodide of iron by mouth the evening and morning preceding operation, continuing daily in this dosage for a week or more thereafter. Iodine in dilute quantities can be given in the post-operative rectal tap water for the first day or two. Following the removal from the hospital, the patient is instructed to continue with the rest treatment for several months. Bland food is given, society avoided and much rest in bed is insisted upon. Experience has demonstrated that the best treatment involves not only many of the therapeutic measures of the internist, but also the all important element of surgery.

SUMMARY

1. The surgical treatment of hypothyroidism of all types is unsatisfactory. Some success is obtained with endocrine gland extracts. Possibly better surgical results may be obtained in grafting human thyroid gland tissue by applying the principle of blood grouping.

2. Acute inflammation of the thyroid gland is treated along the accepted method used for inflammation of other tissues. Chronic thyroiditis demands elimination of the cause. Large goitres, the seat of inflammation in the past, require conservative surgery in order not to produce hypothyroidism. While tuberculosis and syphilis of the thyroid are best cared for by medical measures, size and pressure may be indications for surgery.

3. The avoidance of malignant change in the thyroid depends almost entirely on the removal of nodular tumors in the gland before a definite diagnosis of cancer can be made. Practically all carcinomata of the thyroid develop upon congenital fetal adenomata.

4. Simple goitres have in common the two

factors of size and lack of activity. They may be subdivided into simple colloid, cystic and adenomatous. Adolescent goitres are of a colloid type and are controlled by small doses of iodine, started in early childhood. Colloid goitres and cysts causing disfigurement or pressure require surgical removal. Adenomatous goitre is refractory to any but surgical means.

5. Toxic goitre includes hyperthyroidism of all types. It is generally accepted that hyperthyroidism with adenoma is a surgical disease. It is becoming increasingly evident that hyperthyroidism with hypertrophy and hyperplasia of the epithelial elements of the gland (exophthalmic goitre) is distinctly a surgical condition. The most satisfactory treatment of all types of toxic goitre combines medical factors with surgery.

EFFORTS TOWARD SIMPLIFICATION OF OBSTETRICAL CARE

R. S. SIDDALL, M. D.
(Henry Ford Hospital)
DETROIT, MICH.

For some time we have come to maintain the attitude that child-bearing is now as much a human physiological function as it ever was. Consequently, the members of the obstetrical staff at this hospital have been led to attempt the evaluation of certain of the procedures which were adopted in the enthusiasm of the early efforts to reduce obstetrical mortality and morbidity. The striking reduction of deaths in child-bearing, which followed the adoption of the many procedures advocated in the formative days of the surgical era, cannot be held as sufficient justification for all aspects of the elaborate technic developed at that time, for, with our more matter of fact reasoning, the futility and even danger of some of the procedures must become apparent. Clinical experiments conducted along such lines have established that there are certain unessentials in the usual routine obstetrical care which may be eliminated to no detriment, but rather for the comfort and even to the benefit of patients. The material saving in nursing care alone makes these observations worthy of consideration.

Interest in this direction was shown as early as 1914 when the value of the usual postpartum flushings of the perineum with antiseptic solutions was questioned and subjected to test (1). As a result, the procedure which we now practice is confined to attaining a reasonable degree of cleanliness by washing the perineum with soap and warm water once or twice daily. No antiseptics are employed, nor do we insist upon sterile water or wash cloth. The results are highly satisfactory, perineal tears healing better than when they are being disturbed several times a day by efforts to effect surgical cleanliness. Never has there been any reason to believe that even mild infections have resulted from the technique employed. The same "let alone" care is likewise suitable in cases where secondary repairs have been done.

CARE OF BREASTS

The prenatal treatment of the breasts and nipples which is usually recommended has seemed to us to be most inconsistent, when the methods of treatment and the expected results are considered. According to various textbooks, equally good results are obtained by the use of hardening, astringent solutions or alcohol, or by softening the skin with an oleaginous substances, such as cocoa butter. When measures having such different purposes seemed equally efficacious, we were led to the conclusion that natural processes were the important factors and were probably alone sufficient to prepare the organs for nursing. Consequently, for some time now we have done away with the practice of anointing the nipples, and from our results have become convinced that it is useless to attempt to add anything by treatment to the already adequate physiological preparation for lactation, with the exception that regular traction upon retracted nipples may possibly increase their prominence and usefulness for suckling.

A prolonged trial has also shown that postpartum care of the breasts, when reduced to a minimum, gives surprisingly good results and great comfort to the mothers. It is usually futile to attempt to avoid or even to limit to to any great degree the congestion associated with the establishment of the milk secretion. However, some relief is possibly obtained by limitation of fluid intake and the use of saline cathartics with a consequent reduction of the body fluids. Certainly no good is to be expected from massaging or pumping the breasts as it has been established that such practices tend to stimulate milk flow and therefore really prolong the period of discomfort incident to beginning glandular activity. Accordingly, treatment is chiefly directed toward the relief of the attending discomfort and pain by the application of ice-caps, and by the use of a moderately snug supportive binder to relieve the painful tension from sagging of the heavy breasts. Meanwhile, the law of supply and demand becomes effective, and secretion of the milk is rapidly adjusted to the requirements of the child.

When the facts of the case are considered, the usual routine cleansing of the nipples before nursing, for the purpose of preventing mastitis, at once becomes a debatable procedure. Even could a reasonably clean skin be obtained, its desirability from the standpoint of the child

(1) Plass: "Postpartum Care of the Perineum," Johns Hopkins Hospital Bulletin, 1916, XXVII, 107-109.

would be open to question, when we bear in mind that the type of bacterial flora to be obtained from this source is the one for which the child's intestine is probably best adaptable. However, it seems certain that only a negligible number of the bacteria can be removed from the uneven and folded surface of the nipples and areolae by the customary bathing with the very weak antiseptic solutions which are compatible with the child's welfare. This becomes more evident when it is considered that the most thorough preparation of the hands for operation fails to remove any but the superficial bacteria. The obviously questionable benefit to be derived led us to eliminate the practice from our postpartum care. Between nursings the nipples are protected by square gauze pads which are simply discarded when the child comes to the breast again. Results have been in accord with our expectations, and never has there occurred any ill effect that could be ascribed to the change. Fissured nipples are no more frequent, nor do they heal less rapidly; while mastitis has been very rare, and the incidence of postpartum breast abscess has been zero.

DIET

Our attitude toward dietetics for the patient under prenatal care has for its foundation the belief that as a rule the physiological selective urging of the appetite will determine for her, as it does for the nonpregnant, the foods most needed. This leads essentially to the ordinarily recognized "balanced diet." When it is borne in mind that the growing fetus will obtain the food essentials, if necessary, even at the expense of the maternal tissues, it is reasonable to expect that any marked deviation from a properly proportioned intake may cause damage to the mother. Therefore, for instance, the reduction of proteins below a maintenance quantity during normal pregnancy, in an attempt to reduce the load on the kidneys, has never seemed rational to us.

As a consequence of the observations of Prochownick and others, a diet very low in carbohydrates and fluids has been used rather extensively during the latter part of pregnancy, apparently, we believe, without a clear understanding of the results which may be expected. Without question, it has been established that this regime, when pushed to an extreme, will tend to result in the birth of children definitely below average weight, but probably otherwise normal. It was originally recommended in an attempt to decrease the size of the child and thus give assurance of a spontaneous outcome in cases of moderately contracted pelves. More recently many enthusiastic followers of the teaching have become very skeptical of any real benefit to be derived. When it is remembered that the skull and other bony structures are practically unaffected, and that the lower weight is due to reduction in fat and body fluids, the futility of the attempt becomes apparent. The negligible results obtainable by a diet low in certain essentials and undertaken with some discomfort and possible injury to the mother are scarcely justified, even in the presence of a contracted pelvis, now that Cesarean section offers a relatively safe method of delivery. Certainly, where the pelvis is normal, the treatment has no place.

Following delivery our patients are immediately placed upon full diet in response to the hunger which is present. Liquid, or other limited diet, seems to be in direct violation of the natural requirements and is a relic from the time when the puerperal woman was considered to be ill, and when the sick were placed upon reduced nourishment as a matter of routine. That the sick in general do better on quantities of food sufficient to maintain strength and to insure reasonable resistance to disease is now generally realized. On the other hand, women who have passed through labor are ill only in the sense that there exists a varying degree of exhaustion following the physical exertion involved, and they stand in need of food as does the athlete. No ill result should be expected and has never been observed here, or at another hospital where for some years this reasoning has been followed in practice. On the contrary, both mother and child have been distinctly benefitted by the prompt recovery of strength after labor and early establishment of lactation.

LABOR

The management of labor, except for a few points, does not justify discussion, since it is based upon the firm belief that, in general, spontaneous delivery holds prospects of the best results for both mother and child. During a long first stage the patient's strength may be conserved by the use of pantopon, which gives considerable analgesia and promotes relief and rest between the pains. In our experience this drug, when so used, has a negligible effect both upon the efficiency of uterine contractions and upon the child, unless it is given within two hours of birth. When it seems that labor will be completed within a few hours, usually toward the last part of the first stage in primiparae or earlier in multiparae, nitrous oxide and oxygen analgesia is begun. This anesthetic when given only during uterine contractions does not impair their strength, but rather by the almost complete obliteration of painful sensation results in stronger and more effective voluntary expulsive efforts. In our hands labors so conducted are more rapidly completed and have an extremely low operative incidence. Our experience in regard to occiput posterior

positions is in accord with that of Plass (2) published in 1916. When such cases are treated expectantly, they are not the *beete nois* of obstetrics as has been so often stated, but really demand operative interference only slightly more frequently than do anterior positions.

As a result of the experiments published by Johnston and Siddall (3), we have discarded the usual scrub and flush method of preparation of the vulva for delivery because of the possible danger of introducing contaminated solutions into the vagina, and are using tincture of iodine diluted with 3 parts of alcohol. The only objection to this quick and simple preparation is the burning pain associated with the application of the solution. This is obviated by a few breaths of nitrous oxide and oxygen. When vaginal examination is required, the same preparation is effected, although only a small section of the region is painted. We see no reason why picric acid solutions should not be just as satisfactory.

THE CHILD

It has been found that general care of the newly born child may well be directed only towards external cleanliness, a constant warm temperature, and sufficient food and water as indicated by the weight. We cannot hold that any of the important details of this simplified system of treatment are original with us. However, the advantages are so generally unrecognized that it seems justifiable to mention at least two of them. By the use of the Ziegler cord clamps, one may obviate any risk of hemorrhage from the umbilical cord, and changing of the original dressings is ordinarily unnecessary since separation usually takes place within three or, at the most, four days. Textbooks still advocate the routine cleansing of the child's mouth before nursing upon the assumption that some of the bacteria may be deposited upon the mother's nipples with dire results. That any reasonable efforts to free such uneven surfaces of bacteria, even if desirable, would be futile, should be self-evident. Certainly scrubbing the tender buccal mucous membrane frequently leads to abrasion, and such injury may conceivably offer a *locus minoris resistentiae* for the growth and discharge of perhaps more virulent bacteria, thus aggravating the condition for which the treatment was instituted and also jeopardizing the child. Moreover, the incidence of thrush becomes so low among babies whose mouths are not subjected to the danger of trauma by scrubbing that its appearance is scarcely considered.

CONCLUSION

These departures from the usual routine care which have been adopted will doubtless in the near future be thought of as a very conservative advance toward simplification and improvement in the care of obstetrical patients. Certainly in our experience the facts that have been presented here seem to be well established. Other changes which are indicated by theoretical considerations are either still on trial or have yielded results which do not justify our recommendation at this time.

We especially wish to emphasize the following:

1. Postpartum care of the perineum may be safely limited to that necessary for personal cleanliness, even though perineorrhaphy has been performed.
2. No particular ante partum or postpartum attention to the nipples is of value except in the presence of definite abnormalities (retracted or cracked nipples, etc.)
3. In general, the dictates of the appetite furnish the best regulators for the diet of the pregnant and puerperal woman, and complicated dietetic regimes offer little advantage.
4. The judicious use of opiates during the first stage of labor and of gas-oxygen in the second stage increases the probability of spontaneous delivery. Iodine preparation of the vulva for delivery has certain advantages.
5. The care of the new-born should be limited ordinarily to supplying it with proper food, comfortable warmth, and a reasonable degree of cleanliness.

(2) Plass: "A Statistical Study of 635 Labors with the Occiput Posterior," Johns Hopkins Hospital Bulletin, 1916, XXVI, 164-177.

Johnston and Siddall:

(3) Is the Usual Method of Preparing Patients for Delivery Beneficial or Necessary?" American Journal Obstetrics and Gynecology, 1922, IV., 645-650.

PREVENTION AND TREATMENT OF SIMPLE GOITRE*

O. P. KIMBALL, A. M., M. D.
(Cleveland Clinic)
CLEVELAND, OHIO

Since the classical description of myxoedema by Sir William Gull in 1874, in which he states that this condition is in some way due to a lack of thyroid function, a great deal of research has been devoted to a study of the physiology of the thyroid gland. Gull's statement regarding the etiology of myxoedema was verified by Revirdin (1882) and Kocher (1883) when they observed results of the total removal of goitrous thyroids. In 1891 Murray, and in 1892 McKenzie and others began the use of glycerinated extract of the thyroid gland in the treatment of myxoedema and secured very definite results.

The discovery by Baumann, in 1895, that iodine was a normal constituent of the thyroid

*Read before Marquette-Alger County Medical Society.

gland was the first definite information regarding the chemistry of the gland although iodine had been knowingly used for centuries in the treatment of goitre, and knowingly since the time of Coindet (1820). Since Baumann's discovery our knowledge of the physiology of the thyroid gland and of the relation of iodine to its functional activity has progressed very rapidly. In 1902 Baumann and Roos showed that the iodine was bound with the globulin of the colloid and called the resultant compound thyreoglobulin; and as early as 1907 Marine was teaching that the normal function of the thyroid is dependent upon iodine.

It was shown further by Marine in collaboration with Williams and with Lenhart that there is a very definite relation between the iodine content and the histological structure of the thyroid gland. They found that in all the animals studied by them—sheep, ox, pig and dog, as well as man—cellular hyperplasia and hypertrophy are due to a deficiency of iodine, and conversely that in general the iodine store in the thyroid varies directly with the amount of stainable colloid and inversely with the degree of active hyperplasia; so that in the extreme degrees of active hyperplasia seen in cretinoid states of man and animals the iodine store may be entirely exhausted. They found also that if iodine is given to an animal with a hyperplastic thyroid the gland immediately returns to the colloid or resting state, the nearest approach to the normal gland that a gland which has once been hyperplastic can make.

It has also been emphasized by Marine that there is but one cycle of changes through which the thyroid can pass. Starting with the normal thyroid there is a decrease in the iodine store and a corresponding decrease in stainable colloid. If the iodine store falls below 1 mg. per gram of dried gland active hyperplasia begins. Normal thyroid cells are flat or cuboidal in shape and are arranged in layers. With the development of hyperplasia the cells become columnar and are piled up until the solid mass of cells fills the acini. This is the characteristic picture of active hyperplasia following which one of two things must happen; (a) if the iodine deficiency is not met the process goes on to cellular degeneration and atrophy; or (b) if the iodine deficiency is met the cells will return to the colloid or resting stage, in which the gland may be functionally normal.

This cycle of changes may take place many times, the resulting colloid goitre being somewhat increased in size with each change. The physiology of this cycle of thyroid changes is the same whether it occurs at puberty, during pregnancy or in the course of the syndrome known as exophthalmic goitre.

The thyroid gland has an extraordinary affinity for iodine and the amount taken up by any given thyroid varies with the degree of active hyperplasia. The maximum store is relatively constant for most mammals, and in those thus far studied averages between 5 and 5.5 mgs. per gram of the dried gland. The minimum amount necessary for the maintenance of normal gland structure is likewise constant—averaging about 1 mg. per gram of the dried gland. The average normal iodine content of the human thyroid gland is about 2 mgs. per gram of the dried gland and the maximum total store in a strictly normal human thyroid does not exceed 25 mgs. These facts are of the utmost importance in the practical use of iodine in the prevention and treatment of goitre.

In 1916, Kendall had succeeded in isolating the iodine-containing hormone, which he has termed thyroxin. This is a very stable chemical compound—($C_{11}H_{10}O_3NI_3$), 65 per cent of which consists of iodine. This product produces the same pharmacological effects as the whole thyroid gland. Chemically either of the halogens, chlorine or bromine can be substituted for the iodine and a stable chemical compound will result, but it is physiologically inert.

Early in 1917, the practical application of the principle of the prevention of simple goitre in man was started through the public schools of Akron, Ohio, by Marine and Kimball. Their purpose was to saturate the thyroid with iodine twice each year, and for this purpose two grams of sodium iodid were given over a period of two weeks each spring and fall. The reports of this work were published each year for four years. A summary of the results as tabulated in the fourth paper is given in the following table:

	Taking		Not Taking	
	Totals	%	Totals	%
Unchanged	906	99.8	910	72.4
Normal:				
Increased	2	0.2	347	27.6
Slightly enlarged:				
Unchanged	477	41.9	698	72.8
Increased	3	0.3	127	13.3
Decreased	659	57.8	134	13.9
Moderately enlarged:				
Unchanged	29	20.3	57	64.0
Increased	....	.....	21	23.6
Decreased	114	79.7	11	12.4
	2190		2305	

The small amount of iodine necessary to secure saturation of the gland and the precaution that too much iodine should not be given were emphasized in each publication. It was further suggested that by the administration of a few mgs. of iodine per week throughout the school year maximum results would be secured and the risk of giving too much iodine during a short period would be avoided. Early in 1918 the prevention of goitre

was started in the schools of Zurich, Switzerland, and the suggestion that a few mgs. per week be given throughout the year was adopted. Throughout all the schools in the cantons of St. Gall, Zurich and Berne 5 mgs. of iodine per week has been given to each child for over three years and the reports of the health commissioners of these cantons show even more striking results than have been reported in this country. In all the work in this country and in Switzerland not a single case of hyperthyroidism has developed among those treated. Beginning this year the work in this country has been accelerated by the adoption of this method. Many of the schools in the Cleveland district, in Huntington and Charleston, W. Va., in Hammond, Ind., and in Grand Rapids, Mich., are giving iodine systematically for the prevention of goitre. In most of these cities the school nurse gives to each child one tablet of 10 mgs. of iodine once a week troughout the school year. This seems to be the most scientific and practical manner of administration.

In the Cleveland district only the girls have been urged to take this prophylactic treatment, and in our earlier papers we stated that goitre was about six times as frequent in girls as in boys. However, examination of all boys and girls in the schools of Grand Rapids, Mich., of Hammond, Ind., and of Huntington, W. Va., shows the proportion to be one to two or three instead of one to six. This finding makes it obvious that the prevention of goitre in boys is of much more importance than we had thought and it is therefore urged that boys be included in the application of prophylactic methods against goitre.

Considering the amount of work done and the number of papers written during the past few years on the relation of iodine to thyroid activity, it is little wonder that this conception has become as common as the knowledge of the relation of iron to the redblood-cells. In every article on the prevention of goitre, the efficiency of very small amounts of iodine has been emphasized. Every definite statement that can be made regarding the physiology, the relation of iodine to its histological picture, the chemistry of its secretion and the cycle of histo-pathological changes, emphasizes this same principle. Yet it seems that many physicians think of the relation of iodine to thyroid medication in the same terms as of K I to the treatment of lues. And since we are called upon daily to care for goitres which have developed as a result of excessive iodine medication, it may be well to emphasize a few important points regarding the treatment of these patients.

TREATMENT

First, in the diagnosis of a pathological condition of the thyroid gland its functional activity and not its size should be considered. In the case of a large firm gland of recent development, in which there is no evidence of an increased blood supply and the patient does not show signs of exophthalmic goitre, the condition is an active hyperplasia which needs only iodine, in doses of a few mgs. daily, for involution back to the colloid or resting stage. In dealing with large goitres in adults, most of which are colloid-adenomas of long standing, it seems safer and more rational to consider each case as one of a potential hyperthyroidism. In such cases a sufficiently small amount of iodine should be prescribed and the patient observed carefully at definite intervals.

CASE REPORTS

Case 1. This patient, a young man 19 years of age, had had a small goitre since early childhood (congenital adenoma). Between the ages of 14 and 17 years the gland enlarged and iodine treatment was started, the family physician prescribing a dram of syrup of ferrous idodid after each meal. This medication was continued for 18 months. At the end of the first year the boy was very nervous, could not sleep and was having spells which were interpreted as choreic convulsions; but since the thyroid had decreased somewhat in size the ferrous iodid was continued for six months more. At the end of this period the patient was extremely nervous and the thyroid presented the same appearance as at the end of the first few months' treatment, i. e., it was smaller, but the same nodular masses persisted. The medication was stopped and six months later a thyroidectomy was performed with complete recovery.

Case 2. This patient had always been in perfect health until April, 1922, when she consulted her physician because of a long standing goitre distinctly nodular in type, i. e., an adenoma. A saturated solution of sodium iodid, 5 grains t. i. d. was prescribed. At the end of the first month she returned to her physician complaining of insomnia, palpitation and nervousness, but she was advised to continue the treatment as there had been a slight reduction in the size of the goitre. She continued to take the sodium iodid for two months longer, at the end of which period we saw her. Her condition then could be definitely diagnosed as exophthalmic goitre. Since rest and medical treatment for a period of three months proved ineffective, thyroidectomy was performed, after which she improved rapidly.

Case 3. This patient, who had an adenoma of the thyroid of long standing, began taking sodium iodid of her own volition because she had heard that sodium iodid was being given in the public schools for the prevention of goitre. We have been watching for such a case because when the prophylactic administration of iodine was started in the public schools, it was predicted that indiscriminate self-medication would inevitably result. This, however, is the first case of this kind that we have seen. For three months this patient had taken 5 grains of sodium iodid, t. i. d. with a resultant slight early reduction in the size of the gland. She came to the clinic six months after she began the sodium iodid treatment. Like the preceding case, this patient had a well advanced exophthalmic goitre and the only procedure which can save her from the inevitable outcome of a severe Graves' disease is a thyroidectomy.

These three cases of hyperiodism, one due to

self-medication and two to treatment prescribed by physicians, are typical of many which are constantly applying to us because of symptoms due to excessive use of iodine.

The maximum amount of iodine that the normal thyroid can hold, is, as we have already stated, approximately 25 mgs. The U. S. P. syrup of ferrous iodid contains 41.5 grams of iodine to 1000 cc. and each cc. contains 41.5 mgs. of iodine, and each teaspoonful—the usual dose—contains 166 mgs. of iodine. Therefore the boy whose case was cited first was taking daily 498 mgs. or almost one-half gram of iodine and as this was continued for a period of eighteen months, the boy received a total amount of 269 grams of iodine.

The other two cases cited were using sodium iodid in doses of five grs. t. i. d. or 255 mgs. of iodine per dose or 765 mgs. of iodine per day. Each patient received 69 grams of iodine in three months.

The U. S. P. syrup of hydriodic acid contains 14.5 grams of iodine per 1000 cc. or 14.5 mgs. iodine per cc.

In the treatment of large goitres and especially of long standing colloid-adenomas, a few mgs. of iodine daily—never more than 10 mgs. —will give the maximum effect. The most effective and safest method of administration is by daily doses during alternate months.

In carrying out the functional test on cases of suspected hyperthyroidism, in which the basal metabolism is followed as the chief index to the thyroid activity, the daily administration of 10 mgs. of iodine gives as immediate and permanent effects as does 100 or even 500 mgs. and without the bad results which follow the extremely large doses.

From the point of view of thyroid function it makes no difference what preparation or method of administration is used as long as the thyroid gets iodine in amounts which it can store without excessive stimulation. But from a practical point of view, especially in carrying out the prophylaxis of goitre, the preparation makes all the difference between success and failure. The best preparation of iodine for this purpose appears to be a chocolate iodine combination which has been developed for this purpose, consisting of a vegetable fatty acid (tariric acid—di-iodid), called "Iodostarine," combined with chocolate; each tablet contains 10 mgs. of iodine. This product is very stable, is pleasant to take, is most practical for administration to school children and contains the proper amount of iodine, which makes it perfectly safe.

SUMMARY

(1) Until some method is found whereby the iodine deficiency in our food and drink can be supplied the prevention of goitre should be accomplished through our schools as a matter pertaining to public health and to education.

(2) The administration of iodine in small doses once a week throughout the school year, under the supervision of the school nurse, is the most practical method of goitre prevention.

(3) In the schools of some of the cities of West Virginia, Ohio, Indiana and Michigan, approximately one hundred thousand children and in Switzerland over ninety thousand children are systematically carrying out this prophylactic measure by taking weekly throughout the year, 5 or 10 mgs. of iodine.

(4) Recent examinations, have shown that the incidence of goitre in boys in this state would warrant the application of this principle of goitre prevention to boys as well as to girls.

(5) The prevention of goitre during pregnancy is as important as its prevention during adolescence and should be a part of the routine care of every expectant mother. The same method as that applied to small children can be employed. 10 to 20 mgs. of iodine per week throughout the entire term should be ample.

(6) In the treatment of goitre the dosage of iodine should be considered in terms of mgs. rather than of grs. Ten mgs. of iodine daily for 30 days should be the maximum amount of iodine given to any patient during a single period of administration.

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*A CASE OF GASTRIC SYPHILIS

ROBERT C. MOEHLIG, M. D.
DETROIT, MICH.

Gastric syphilis was at one time so rare that its existence was questioned. Authorities naturally differ as to its frequency, but in reviewing the literature one comes to the conclusion that it is not of frequent occurrence. Mills (1) says, "Probably a fair guess as to its com-

*Read before the Detroit Surgical Society, Feb., 1923.

parative incidence, based on available statistics, is that there is about one case of gastric syphilis to every hundred cases of gastric organic lesions of other sorts, essentially benign ulcer and carcinoma." This would seem somewhat high. It occurs twice as frequently in men as in women. The average age for its appearance is 40 years, and the average duration of symptoms is two years.

The pathology of gastric tertiary syphilis is, briefly, a terminal contractural sclerosis involving the gastric wall, usually the lower and middle thirds, with extension along the lesser curvature. It is a true syphilitis cirrhosis and may result in an hour-glass appearance or an annular prepyloric contraction. There is a shrinkage of the stomach with a resulting diminished capacity. The microscopical picture is one of dense connective tissue infiltration with the usual round cell infiltration and multinuclear giant cells. This may produce a gumma or gummatous ulcer. The symptoms are not characteristic. There is a variation in the clinical picture, depending upon the extent and site of the involvment. Pain after meals, feeling of fullness as soon as anything is eaten, vomiting, nausea, belching of gas, and loss of weight are the usual symptoms. It closely simulates the slowing progressive cirrhous carcinoma. Hemorrhage is an infrequent symptom. Achylia is present in 80 per cent and 20 per cent have subnormal values. There is a marked dimunition of capacity which may account for the ravenous appetite experienced in some cases.

Anemia is marked and cachexia is not infrequent, while loss of weight is present, it is not as marked as in carcinoma.

Eusterman (2) of the Mayo Clinic has reported 65 cases of gastric syphilis. He states that in 50 to 60 per cent of gastric carcinomas, a tumor can be palpated, whereas in syphilis there are 15 per cent of palpable tumors. Free hydrochloric acid is present in 46 per cent of gastric carcinoma in all stages, absent in 80 per cent of gastric syphilis. The Wassermann reaction is positive in the majority of cases.

Carman states that the X-ray findings are not diagnostic in themselves, but coupled with clinical findings, they are of great value.

CASE REPORT

Miss M. O., age 40, nurse, first seen April 14, 1922 following an automobile accident, was brought to Harper Hospital in deep shock, and vomited blood several times. After her recovery her history was gone into more fully. Seventeen years ago she had had a hysterectomy performed for a fibroid. Had had stomach trouble since 1912. Three years ago she had a gastro-intestinal X-ray which showed "a trace of ulcer and a small stomach." One year ago she had another gastro-intestinal examination by another Roentgenologist. He gave the same report. Last June her appetite failed and she lost about 25 pounds. She had belching of gas and felt distressed as soon as she ate anything. Occasionally she felt nauseated. Four weeks before her accident she had regained a few pounds. Since the accident she has lost 10 pounds. She is very anemic looking, but the nutrition is good. Ears, nose and mouth negative. Pupils equal and react O. K. Neck and chest negative. Abdomen, low medium laparotomy scar. Tenderness is epigastrium. No masses palpable. Liver not palpable. Superficial and deep reflexes normal. Wassermann with both antigens. Urine negative. Blood count normal. Hgb 60 per cent.

X-ray May 29, 1923. "The first portion of the mixture to reach the stomach passed quickly into the small bowel. During the ingestion of the rest of the meal the rapid gastric evacuation continued, so that there was only a small amount of the meal remaining in the stomach when the patient was finished drinking. We noted that the upper part of the stomach filled out fairly well, but the lower left was never dilated beyond three-fourths inches. There was a perfectly formed duodenal bulb. The stomach in the region of the defect was pliable. Fluroscopic study, following a second meal, revealed some retention of barium in the upper part of the stomach. The findings point to an organic lesion of the gastric wall. We would rule against ordinary carcinoma as the pathology present. We believe that in carcinoma there would be slow gastric evacuation rather than the very rapid emptying as present in this case. The gastric wall also seems too pliable for carcinomatous infiltration." (Dr. Evans.

She was given the usual course of anti-syphilitic treatment. Three days after the institution of this treatment she gained one and a half pounds and has continued to increase in weight, although not so rapidly as at the beginning. She feels fine and her gastric symptoms are much improved. Her X-ray findings on two different occasions show no change.

Eusterman in fifty-five cases obtained a clinical cure in 42 per cent, improvement in 50 per cent. In twelve cases anatomical restitution to normal was complete.

In differentiating this case from carcinoma:

1. The duration was too long for carcinoma.
2. The extent of the gastric lesion as shown by the X-ray is out of all proportion to the comparatively good condition of the patient.
3. The positive Wassermann.
4. No palpable mass.
5. The therapeutic test.

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Editor and Business Manager
FREDERICK C. WARNSHUIS, M. D., D. Sc., F. A. C. S.
Grand Rapids, Mich.

GUY L. CONNOR, M. D., F. A. C. P.
Associate Editor, Detroit.

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Report Malpractice Threats Immediately to Doctor F. B. Tibbals, 1212 Kresge Building, Detroit, Mich.

Editorials

OUR ANNUAL MEETING

Again we direct attention to the program for our annual meeting, as published in our August issue. We desire to particularly stress and invite your consideration of the following features:

Invited Guests—Among the prominent men who will address us are: United States Senator W. N. Ferris, Rev. A. W. Wishart, Dr. Geo. H. Simmons, general manager and editor of the Journal of the American Medical Association; Dr. Olin West, secretary of the A. M. A.; Dr. Woodard, executive secretary of the Bureau of Legal Medicine and Legislation of the A. M. A. These men will appear before our general sessions and will have messages that are of personal concern to every doctor and to our society. You should grasp this opportunity to hear them.

Section Guests—The officers of our scientific sections have invited men pre-eminent in our profession to discuss pertinent subjects before our several sections. Their presence should inspire a large attendance. They are: Doctors L. Brown, Saranac Lake, N. Y.; Kennon Dunham, Cincinnati, Ohio; W. S. Petersen, Chicago; E. E. Irons, Chicago; Frank Smithies, Chicago; M. E. Rehfuss of Philadelphia, Pa.; Willard Bartlett, St. Louis, Mo.; S. D. Giffen, Toledo, Ohio, and Joseph Brenneman of Chicago.

Section Features—The Section on Ophthalmology and Oto-Laryngology has arranged a remarkable program covering three days and features papers, clinics and round-table discussions. It is a most splendid section program.

House of Delegates—The House of Delegates will have presented to it several important matters that demand the presence of representatives of every County Society. The House will hold its first session at 2:00 p. m., on September 11th.

Entertainment—As guests of the Kent County Medical Society, suitable and pleasing entertainment will be provided.

So we repeat, plan to attend this annual meeting in Grand Rapids on September 11, 12 and 13th. Get there the first day and stay through to the evening of the 13th. You will enjoy every minute and profit handsomely. Refer to the August issue for specific details. Grand Rapids bids you welcome.

DELEGATES—ATTENTION!

The first session of the House of Delegates will be held at 2:00 p. m., September 11th. Second session at 7:00 p. m. Third session, September 12th at 8:00 a. m. Fourth session, September 13th at 8:00 a. m.

As a delegate you are not only expected, but it is your duty to be in attendance at *all* of these sessions. You are not representing your county society if you fail to attend. Your county society has the right of representation and as delegate you must not fail them.

Credential cards have been mailed to all county secretaries to hand to their delegates. These cards should be presented to the Credential Committee and *not* at the Registration Booth. The Speaker has appointed the following Committee on Credentials: Doctors C. S. Gorsline, D. J. O'Brien and G. H. Yeo. This committee will pass on all credentials and will be in session before each meeting of the House. Present your credentials to this committee.

HOSPITAL, CLINIC AND GROUP ADVERTISING

As associated members the Principles of Medical Ethics govern our professional activity and conduct. As it governs individuals so to does it apply to groups or combination of individuals engaging in medical practice.

Evidence is at hand that indicate that these principles are being ignored or overlooked by hospital staffs and group clinics. The sentiment and attitude seems to be that hospital staffs and group clinics can do what individuals cannot do. We find hospitals sending out advertising literature and using the columns of daily papers to broadcast their work, services and bidding for patients. We find local, limited groups doing likewise.

This is direct, open violation of our Code of Medical Principles.

Such practices should not be permitted to continue. Persistent pursuit of such practices should be inquired into by our county societies and these violations terminated as promptly as possible.

For guidance we quote, Section Four of Chapter II of the Principles of Medical Ethics:

ADVERTISING

Section 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not per se improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

We trust hospital superintendents and clinic directors will observe the principle laid down in the above section.

CUTTING DOCTOR BILLS

It seems to be the tendency and practice of corporations, insurance companies and municipalities to cut bills rendered by doctors for professional services to employees. State Compensation Commissions also assume to dictate what financial returns a doctor is to receive for professional services rendered in compensation cases.

The practice and policy is unjust and unfair. It is a trespass upon a doctor's right. It is a practice that is not upheld by law. But it is being done and by bluff and bull-dozing the doctor is told that so much will be allowed on his bill, and that such allowance is in accordance with fee schedules instituted by the Compensation Commission, etc. The result, the doctor, ignorant of his rights, accepts the cut of his bill and is underpaid. The insurance company or corporation has saved money and received professional services at a reduced rate. We repeat, it is wrong. We urge that you do not accept these cuts. Stand on and insist on your just rights. We quote the following decisions:

COMPENSATION FOR SERVICES REQUESTED BY EMPLOYER

(Weinreb v. Harlem Bakery and Lunch Room, Inc., N. Y., 197 N. Y. Supp. 833)

The supreme court of New York, Appellate Division, First Department, in affirming a determination of the appellate term that affirmed a judgment in favor of the plaintiff, says that the action was brought by a physician to recover the reasonable value of his services rendered at the request of the defendant to a man who was injured while in its employ and during the course of his employment. Two defenses were set up: (1) That the court did not have jurisdiction of the action, as the workmen's compensation law of the state confers exclusive jurisdiction on the compensation commission to determine the value of physicians' charges in such cases, and (2) that the action was barred by the workmen's compensation law. But the court does not accept the defendant's views. When the employer provides the medical attendance and treatment, the compensation of the employe for injuries must be based solely on the loss of earning power. It is only in the case of the employer's refusal or neglect to furnish the necessary medical attendance or treatment that the expense thereof can be recovered as a part of the employe's compensation for his injury. In the latter case, the fixing of the reasonable value of such service is exclusively vested in the commission and allowed as a part of the employe's compensation, and the amount fixed becomes a lien on the compensation awarded. The statute does not concern itself with the contract that the employer makes with the physician or surgeon, when the employer provides the medical attendance. He is at liberty to make any agreement that to him seems proper, and make such payment as he may stipulate, for the amount that he pays is not a part of the compensation to be awarded. If the employer hires the physician, it is simply a matter of contract between the physician and the employer. If the amount to be paid is stipulated, the physician is entitled to that sum. If no amount is named, the physician is entitled to receive the reasonable value of his services. A failure to pay gives rise to a common-law action that may be prosecuted in the courts. There is no more reason for giving the commission the right to limit or control the sum to be paid under this contract of employment than there would be to require all contracts with employes to be submitted to the commission to pass on the reasonableness of the wages agreed to be paid.

COMPENSATION FOR SERVICES REQUESTED CLAIMS OF PHYSICIANS AND HOSPITALS UNDER CONTRACTS

(Western Indemnity Co. v. State Industrial Commission et al., Okla., 211 Pac. R. 423)

The supreme court of Oklahoma says that an employe of a company sustained an injury that entitled him to compensation under the workmen's compensation law of that state. Some weeks afterward, the state industrial commission made an award and ordered the employer, or the indemnity company that was its insurance carrier, to pay the amount of the award and also "all medical expenses as may be necessary as the result of said injury during 60 days after the injury or for such time in excess thereof as in the judgment of the commission may be required. Such charges shall not exceed the sum of $100 unless approved by the commission." When the employe was injured the employer directed him to a physician, and placed him in a hospital. The medical bill incurred was $135, and the hospital bill $232.80. The employer paid the hospital bill. The physician's bill was not paid. The insurance carrier paid to the employer, on these amounts, $100. Thereafter a review was had of the medical bill and hospital bill by the industrial commission, and the commission made finding that the claims of the physician and the hospital were reasonable charges, and ordered the employer or the insurance carrier to pay the physician $135, and that the insurance carrier reimburse the employer in the sum of $132, that being the balance of the hospital bill after crediting the insurance company with the $100 theretofore paid. But the award of the commission is reversed and remanded, with direction to dismiss the claims, because the commission is without jurisdiction to hear and determine claims of this character. In other words, the court holds that the industrial commission of Oklahoma is without jurisdiction to hear and determine the reasonableness or unreasonableness of claims for medical or hospital services when they are based on a contract between the employer and the physician, or on one between the employer and the hospital furnishing services to an injured employe entitled to compensation under the provisions of the workmen's compensation law.

MARTYRS IN MEDICINE

When a man lays down his life for country, principle or calling, he becomes enshrined in our memory and assumes a place among those who posterity reveres, in greater or less degree, as martyrs.

Our profession has contributed many martyrs, whose lives have been offered for country, state and society. The list is long, with many outstanding names. Some made the supreme sacrifice for country, some for science and some for society. We honor them; we revere them. To us it has always seemed that the greatest martyrs were not those whose sacrifice was associated with the glamor of heroics, or, the pre-eminence of environment. Commendable as may have been their sacrifice, and meritous of all honor, still compensated in a degree by the deed and the occassion. Greater, indeed, the martyrdom of him or her, who in the faithful performance of their daily and sometimes monotonous routine, meet death and give their lives while laboring along the quiet by-paths of life.

Such was the fate of one of our fellow-members, Dr. W. S. Shipp of Battle Creek, who on July 25th gave his life for duty, society and country when he fell from the bullets of an assasin in the person of a demented ex-service man. The incidents surrounding his death are imparted elsewhere in this issue. We pause to pay honor and respect. We desire to record his name among the martyrs of our profession.

CAUSES OF DEATH

In a review, covering a period of five years, five of our leading life insurance companies have compiled an interesting statistical study of the causes of death among their policy holders and health registration areas.

Tuberculosis heads the list with a death rate in 1920 of 154.5 per 100,000. A showing that still deserves the thought of health officers ere they become too imbued with the pursuit of fads and fancies. In addition to ranking as the leading cause of death, it stood first at the following age periods: 15-19, 20-24, 25-34, 35-44, and 45 to 54 years.

Influenza and pneumonia ranks second as a cause of death.

Organic heart disease is third in numerical importance, with a death rate of 127.5 per 100,000. It is estimated that over 2,000,000 people in the United States are suffering from serious heart impairments.

Bright's disease ranks fifth with a death rate of 84.7 per 100,000.

Accidents causing death was sixth with a rate of 73.2 per 100,000.

Cancer, with a rate of 72.0 per 100,000 is seventh on the list.

Cerebral hemorrhage, apoplexy, is eighth with a rate of 62.8 per 100,000.

Next comes four communicable diseases, measles, scarlet fever, whooping cough and diphtheria.

The puerperal state, including all conditions dependent upon pregnancy and partuition, together with affections of the breast during lactation, was 20 per 100,000. In the U. S. 19 per 100,000; 33 per cent of these deaths were due to septicemia, 24 per cent to albuminuria and convulsions, 16 per cent to the accidents of pregnancy and 15 per cent to the accidents of labor, with the remaining 13 per cent caused by embolism, heart disease and phlegmasia.

Diseases of the arteries caused a death rate of 15.6 per 100,000.

Diabetes is the next death cause with a rate of 15.4 per 100,000. Appendicitis has a death rate of 11.2 per 100,000; cirrhosis of the liver, 10.1 per cent; typhoid fever, 8.3; acute polio-

myelitis, 3.2; cerebrospnial fever, 1.5; pellagara, 3.2, and malaria, 8 per cent.

There is much for reflection in these figures. There is a definite warning to the profession.

Editorial Comments

The annual meeting of the College of Surgeons and the Clinical Congress of Surgeons will be held in Chicago in October. An attractive and instructive clinical program has been arranged.

County Secretaries are requested to state, when registering, that they will attend the luncheon on Thursday noon with the members of the Council. Every county secretary is expected to attend.

Have you sent in to the secretary of the A. M. A. your application for Fellowship in the A. M. A.? If not, do you not feel that you should? Michigan doctors should support the American Medical Association by becoming a Fellow. The Journal of the A. M. A., which is sent you is worth the Fellowship fee a hundred times over. Join now. Support those who are constantly active in your behalf.

If you have been undecided as to whether you were going to Grand Rapids on September 11, 12 and 13th to attend our Annual Meeting, we suggest that you turn to the program in the August issue. Inform yourself as to the invited guests who are to read papers and the other features of the section programs. We feel certain, that with this information, you will want to attend this meeting. Make up your mind now. Write for reservations and do not miss this meeting.

The Journal expresses its appreciation to those of our membership who have contributed to the support of The Journal by causing their professional announcements to appear in our advertising section. The number is comparatively small, especially when we compare the number of such announcements with those appearing in other state journals. However, we are hopeful that there are other members who are willing to contribute similar support and that with resumption of practice, after vacations, we may receive their requests for space. Just drop us a line telling us to insert your card and enclose copy. Will you contribute this support? Turn to our advertising section and join these men who make their contributions for a better and larger State Journal.

We were quite proud of our August issue. Especially because of the mint of information that was imparted in the reports from the American Medical Association. Did you read them? Did you learn what was being done to solve the nurse question? Did you glean what is being formulated for postgraduate medical instruction? Did you perceive what our national organization is doing in medical legislative matters? Did you glimpse the plans for future medicine and the doctors' welfare in President Wilbur's address? Did you become enlightened upon what the A. M. A. is really doing for you? If you missed these wonderful, constructive efforts, turn again to the last issue and read those reports again. No physician should be without that information. So turn back, brother, and get abreast of medical activities.

Last month we devoted considerable space to the publishing of reports that revealed the work that was being done by the American Medical Association. We desired to impart to you more definite information as to what our national organization is accomplishing in your behalf. We also pointed out the difference between membership and fellowship in the A. M. A. We believed that with this information you would want to become a Fellow of the A. M. A. Have you made application? If not, do you not feel that you should? Then why not do it now? Again we urge that you support your national association. Make application for admission as a Fellow and in addition to all the other benefits of Fellowship you will receive the Journal of the American Medical Association and also a monthly copy of the Bulletin.

Insulin is in the limelight, and rightly so. The use of Insulin in the treatment of diabetes is the most important advancement of medical therapy of the year. It is a most potent and effective agent when scientifically exhibited in the treatment of diabetes. It is not a specific. It is not a cure-all. It cannot be routinely administered without the most careful and detailed laboratory examination of your patient's blood and metabolism rate. It cannot be given by mouth, in spite of the advertisements and literature of some drug firms. It is a remedy that is potent of doing much harm and even producing fatalities if its administration is not properly safeguarded and a normal blood-sugar ratio maintained. Again, it is a remedy that wll produce most startling and beneficial results when properly administered. Do not be too cocksure and employ Insulin injudiciously. Or, as we heard one man remark: "Oh, well, we will operate anyhow, even if she is a diabetic, and if we get into trouble we will just shoot her some Insulin." Heaven forbid the further development of such an attitude among surgeons and doctors.

Thoroughness and completeness of examinations of patients consulting physicians is woefully lacking. It is disheartening to review the penalties to the patient and also to the physician that result from neglect of thorough and complete physical examination. Especially is this true in conditions involving the rectum. Doctors have stethescopes, auroscopes, ophthalmoscopes, urethroscopes, vaginal specula, lights, illuminators and other diagnostic instruments. The proctoscope is absent. Yet witness the many cases of rectal disease and malignancy. Many of them, and especially the malignancy, are well advanced before they reach the thorough examiner and then too late to accomplish a cure.

When a patient presents, complaining of hemorrhoids, fissures or hemorrhage from the rectum, does the average physician make an examination to determine the condition? No. it's a prescription for an ointment or a suppository and "Let me know if you don't improve." This "let me know" is continued and drawn over weeks and even months. Then your patient goes where he can and will secure a thorough examination. And alas, when he does, how often the diagnosis, inoperable, advanced carcinoma. Neglect has caused the doom of the patient. We urge that you examine patients complaining of rectal disease. We urge that to your many "scopes" you add the proctoscope and use it.

State News Notes

Dr. H. S. Collisi, Grand Rapids, spent the month of August in Topinabie.

Dr. G. H. Southwick, Grand Rapids, spent the month of August in Canada.

Born, to Dr. and Mrs. B. R. Corbus, Grand Rapids, a daughter.

Born, to Dr. and Mrs. M. M. Dewar, Grand Rapids, a son.

Dr. R. W. Webb, Grand Rapids, spent his vacation in Canada.

Dr. and Mrs. H. R. Varney of Detroit, spent the month of August at LeCheneaux club.

Miss Beatrice Biddle, only child of Dr. and Mrs. A. P. Biddle of Detroit, died August 7, 1923.

Dr. Roger V. Walker of Detroit, was married to Miss Helen F. Reade of Escanaba, August 16, 1923.

Dr. and Mrs. F. W. Robbins of Detroit, spent six weeks this summer in a tour through New England.

Dr. and Mrs. F. B. Tibbals of Detroit, spent the summer in their cottage on Hickory Island.

Dr. and Mrs. John C. Dodds of Detroit, spent the summer in Europe.

Dr. and Mrs. E .L. Roach of Wyandotte, spent the month of August motoring through the east.

Twenty physicians took the special insulin course, given by the University of Michigan this summer.

Dr. R. J. Hutchinson, Grand Rapids, returned September 1st from a two months' vacation, spent in his camp in Canada.

Dr. H. J. Beel, Grand Rapids, has opened offices in the Metz building, severing his association with Dr. R. J. Hutchinson.

Dr. Mary G. Haskins of Detroit, spent the month of June and the first half of July on her farm in Connecticut.

Twenty-five thousand dollars has been raised in this country during the past 15 years through the annual Christmas Seal sales.

At the July meeting the board of governors of the Detroit Athletic Club elected to membership Dr. George P. McNaughton and Dr. R. V. Walker.

Dr. and Mrs. C. A. Fettig of Detroit, announce the engagement of their daughter, Miss Jean L. Fettig, to Mr. L. S. Palmer of Detroit.

Dr. and Mrs. Neil Bentley and family of Detroit, spent the month of July at Harwichport, Cape Cod.

Dr. and Mrs. F. B. Tibbals of Detroit, announce the engagement of their daughter, Miss Margaret B. Tibbals, to Mr. H. M. Shaw of Detroit.

The eighth annual meeting of the American Association of Industrial Physicians and Surgeons will be held in Buffalo, October 1-3, 1923.

The American Association for the Advancement of Science will hold its seventy-seventh meeting in Los Angeles, September 17-30, 1923.

Dr. and Mrs. G. B. Hoops of Detroit, spent the month of July touring in the east. They stopped in Boston, New York and other eastern cities.

Dr. and Mrs. H. H. Johnson of Detroit, spent the summer at Winthrop Beach. The doctor took a summer course at Harvard.

Dr. and Mrs. George Waldeck of Detroit, spent the month of August at Havenside, Martha's Vineyard.

Dr. William H. Welch of Baltimore, received the honorary degree of Doctor of Science from the University of Cambridge, England, June 12, 1923.

Dr. and Mrs. George H. Palmerlee of Detroit, took a six weeks' motor trip through New England this summer.

There are six open air schools (enrollment, 709,) and nine open window rooms (enrollment, 401,) in the public schools of Detroit.

The Upper Peninsula Medical Society held its annual meeting in Iron Mountain, August 22-23, 1923.

Mrs. Warren L. Babcock and family of Detroit, spent the summer at their cottage on Hickory Island. Dr. Babcock joined his family over week-ends.

It is reported that construction on the ten-story Professional building, Grand Rapids, will be started in October. Building to be completed by October, 1924.

Dr. Joseph Johns of Ionia, returned on July 28th from a trip abroad. He was clinical assistant surgeon in the Royal Infirmary of Glasgow for a period of three months.

Professor Wenckeback, chief of the first medical clinic of Vienna, gave a lecture and held a clinic on heart disease at the Battle Creek Sanitarium on August 7th.

Dr. B. R. Shurly of Detroit, was re-elected delegate from the Section on Laryngology, Otology and Rhinology to the House of Delegates of the American Medical Association for the coming year.

The thirty-sixth annual meeting of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons will be held in Philadelphia, September 19-21, 1923.

Dr. W. W. Keen of Philadelphia, attended the sixth triennial congress of the International Surgical Society, held in London, England, July 17, 1923. Dr. Keen is 86 years of age.

Dr. and Mrs. William M. Donald of Detroit, spent the summer in their cottage at Clarkston, Mich. Dr. and Mrs. Douglas Donald spent the month of August with their parents.

Dr. L. J. Hirschman of Detroit, was elected delegate from the Section on Gastro-Enterology and Proctology to the House of Delegates of the American Medical Association for the coming year.

Dr. Livingston Farrand, president of Cornell University, was recently elected president of the National Tuberculosis Association at its annual meeting, held in Santa Barbara, California.

Dr. Frederick P. Gay has resigned as Professor of Bacteriology in the University of California to become Professor of Pathology in Columbia University, New York.

Governor Smith of New York recently appointed Dr. Simon Flexner, chairman of the Public Health Council, and Dr. Mattias Nicoll, Jr., State Commissioner of Health.

The Chicago Medical Society is the largest local medical society in the world, having 3,771 active members, 50 honorary members and 43 non-resident members.

Dr. Guy L. Connor of Detroit, gave an address at the banquet of the Upper Peninsula Medical Society meeting in Ironwood on August 18th. Dr. W. T. Dodge also attended and was one of the speakers at the banquet.

Dr. Guy H. McFall states that, during the past 14 years, on an average, 20 per cent of the tuberculosis patients at the Herman Kiefer Hospital, Detroit, have laryngeal lesions.

The fifth Year Interne Course at Harper Hospital, Detroit, includes: Surgery, 28 weeks; Medicine, 16 weeks; Obstetrics, 8 weeks. In addition the interne will be given an extra course in special laboratory work and in anesthetics.

The Canadian government has granted Dr. F. C. Banting an unconditional annuity of $7,500 a year. He is the first incumbent of the Banting-Best Chair of Research in the University of Toronto (salary $6,000 yearly). Thus the doctor has an assured income of $13,500 a year.

The council of the British Medical Association will entertain as the guest of the evening at the council dinner (October 24, 1923,) Sir Dawson Williams, who has completed 25 years as editor of the British Medical Journal.

The Medical Veterans of the World War elected the following officers at its annual meeting, held in San Francisco, June 28, 1923: President, Dr. J. C. Vaux of Pittsburgh; vice president, Dr. B. F. Adler of San Francisco; secretary, Dr. A. T. McCormack of Louisville.

Beginning July 1, 1922, the Out-Patient Department of Harper Hospital, Detroit, began to make a charge for each patient's visit. The attendance has not been diminished by this practice. The number of cases of minor illnesses has diminished, but the number of cases of serious ailments has increased.

The Michigan supreme court held (case of Frankamp v. Fordney, et. al.,) that typhoid fever, contracted by an employe of a hotel as a result of drinking water furnished by the hotel, is compensable as an accident within the meaning of the workmen's compensation act.

The Henry Ford Hospital, Detroit, has offered free treatment to disabled world war veterans. More than 50 are already under treatment. In extreme cases of destitute families of former service men, children needing hospitalization will be treated when designated by the office of the American Legion.

During the past year 523 tuberculosis patients were admitted to the Herman Kiefer Hospital, Detroit, (209 deaths:) 616 to the Northville Sanatorium (38 deaths:) 69 to the Eloise County Hospital (15 deaths:) 100 to the Summer Recuperation Camp for Children.

At the twenty-fourth annual meeting of the American Therapeutic Society, held in San Francisco, June 23, 1923, the following officers were elected: President, Dr. G. H. Evans of San Francisco; vice presidents, Doctors C. I. Greene of St. Paul, W. F. Milroy of Omaha, and R. D. Rudolf of Toronto; secretary, Dr. L. H. Taylor of Washington, D. C.; treasurer, Dr. S. L. Dawes of New York.

During the past school year the Detroit Department of Health, in co-operation with the Detroit Board of Education, conducted 99 nutrition classes (an enrollment of approximately 1,500), for severely underweight and undernourished children. The classes were chiefly educational in character and designed to develop proper health habits. Each class lasted only 12 weeks and its personnel was entirely made up of children who were 15 per cent or more underweight. It was not expected that the small amount of supplemental feeding given (a half pint of milk and two graham crackers) would in so short a time enable any large proportion of the children to get back to normal weight. As a matter of fact, 2 per cent of the children reached normal weight at the conclusion of the classes. However, if the instructional work has been interestingly given, the health habits will continue long after the class has ceased and through them the child will eventually reach normal weight and, what is of greater importance, he or she will probably stay there.

C. M. Sampson, formerly chief of the Physiotherapy Department of the Mammoth U. S. P. H. S. Hospital, No. 41, at Fox Hills, Staten Island, N. Y., and at present engaged in lecturing in the various medical centers, is scheduled to give a series in Detroit, beginning October 8th. At the Fox Hills clinic, much original research work (such as the method of preventing and clearing up X-ray burns) was accomplished. A personnel of 110 operators averaging at times over 2,300 treatments per day, was here trained and directed by Dr. Sampson. One of the lectures included with this course was a 6,000-foot film to illustrate his work there. Major Sampson is devoting much energy to the question of ways and means for eradicating the "incubus of the short-cut therapy cults," as he terms it, and as many eminent leaders in the medical profession are now interested in his work an unusual impetus is being given this movement. For further details regarding these lectures address Manager, Major Sampson Detroit Lecture Course, care A. T. Newton, 641 David Whitney building, Detroit.

County Society News

HOUGHTON COUNTY

The July meeting—The Society accepted the invitation of Dr. John Moore to his bungalow on the shores of Portage lake. A sumptous supper was served to 20 members and their wives. All present thoroughly enjoyed the doctor's hospitality and three cheers and a tiger were given Dr. and Mrs. Moore as an expression of appreciation of a most enjoyable evening.

The August Meeting—The staff of the Memorial Hospital of Laurium presented the following program with clinical cases:

1. "Progressive (Spinal) Muscular Atrophy," Dr. George Reese.
2. "Sarcoma of the Neck," Dr. Andy Roche.
3. "Prostatectomy," Dr. H. M. Joy.

Lunch was served by the hospital nurses.

The Medical Society is enjoying these meetings at the different hospitals and we are having a most excellent attendance and program. The presentation of clinical cases enlivens the papers and the discussions.

The September meeting will be given by the staff of St. Joseph's Hospital at Hancock.

A goodly number of this society will attend the Upper Peninsula Medical Meeting at Iron Mountain, August 22 and 23. Also the state meeting in September.

Charles E. Rowe, Secretary.

Book Reviews

EXCURSIONS INTO SURGICAL SUBJECTS—By John B. Deaver, M. D., and Stanley P. Rieman, M. D. Octavo volume of 188 pages and 30 illustrations. Price $4.50, net. W. B. Saunders Company, Philadelphia, Pa.

When Deaver writes or speaks, the surgical world particularly and the medical profession especially, pause, listen, learn and profit. In this volume he discusses Peptic Ulcer, Jaundice, Diseases of the Bile Passages, Trials of a Surgeon, Surgical Conditions of the Intestinal Tract, Pasteur's Contribution to Modern Surgery, Medical Education and Living Pathology. An array of topics upon which we recognize Deaver as an authority and master. Every medical man, surgeon or internist, should acquire this valuable text. It is a most meritous addition to our medical literature. We commend it heartily.

PHYSIOTHERAPY TECHNIC: C. M. Sampson, M. D., 85 illustrations, 434 pages. Price $6.50. C. V. Mosby Company, St. Louis, Mo.

If this text was in the hands of every doctor, if every doctor obtained thereby a proficiency in physiotherapy, if every doctor employed physiotherapy, then there would be fewer cults who treat class of patients. This is a splendid, lucid text written by a man of extended experience and who had an additional wonderful experience in the physiotherapy service of the army. Physiotherapy is of equal importance as is therapeutics, and surgery. It is a potent for results. Pity is that doctors neglect it. This text will enable you to employ physiotherapeutic agents and secure results. We commend without reservation.

THE MEDICAL CLINICS OF NORTH AMERICA—July, 1923. Published bi-monthly. W. B. Saunders Company, Philadelphia, Pa. Yearly subscription, $12.

The July number is the Mayo Clinic number, with articles by members of that staff. There are four interesting, instructive articles on Insulin. The other articles cover a varying, wide range of subjects of practical and timely interest. Certainly the whole number consists of wholesome, scientific educational manuscripts.

PAPERS FROM THE MAYO FOUNDATION—Papers from the Mayo Foundation for Medical Education and Research and the Graduate School of Medicine of the University of Minnesota, covering the period of 1920-1922. Octavo volume of 716 pages with 257 illustrations. Cloth, $10 net. W. B. Saunders Company, Philadelphia, London.

As the title implies, this volume imparts important papers and reports of investigations and studies of this school. Some of the theses and studies are of exceptional value and interest. Some are not. Again, the collection is disappointing by reason of so many abstracted articles, which in their abstracted form are of little value and interest. They might better have been simply listed by title. About the poorest text issued by the Mayo Foundation.

INTERNATIONAL CLINICS: Vol. II.—1923. J. B. Lippincott Co., Philadelphia.

Always a text of valuable information and instructive. More so in this issue because of a complete discussion on Insulin and diabetes. The way the subject is covered makes this number of triple value. We urge that you read the presentation. The other articles are up to the established high standard of the clinic.

PRACTICAL DIETETICS—Alida Frances Pattie. Fourteenth revised edition.

Practical Dietetics is the latest and most authoritative dietetic text issued since the publication of the "Recent Outline of a Course of Study in Dietetics" issued by the American Dietetic Association. Pattee's Teacher's Dietetic Guide—given gratis with "Practical Dietetics"—includes this outline with specific reference to pages in "Practical Dietetics" where replies may be found. "Practical Dietetics" also follows the outline arranged by the National League of Nursing Education.

The theoretical and the practical side of dietetics are so treated as to insure the student's application of theory in practice. Reference to a recipe automatically calls attention to its function in nutrition. Special emphasis has been laid upon the source and value of the A, B and C vitamines and the recipes in general use today.

Collaborators. Professor Mary Swartz Rose of Teacher's College, New York City; Harriet T. Barto, assistant professor of dietetics, University of Illinois; Emma F. Holloway, supervisor of institutional

work and hospital dietetics, Pratt Institute; Frederic W. Howe, director of school and household science and arts, Pratt Institute, Brooklyn, N. Y., have very kindly assisted in the arrangement of the theoretical portion of the work.

Diet in Disease has been arranged under the personal supervision of leading members of the medical profession, each giving diets used in his own highly specialized field.

The author acknowledges the assistance of such eminent authorities as Dr. Warren Coleman, Dr. Elliott P. Joslin, Dr. Frederick M. Allen, Dr. Max Einhorn, Dr. Herbert S. Carter, Dr. B. Franklin Stahl, Dr. L. Emmett Holt; Bellevue Hospital, St. Luke's Hospital, New York; Loomis Sanatorium, Loomis, New York; Massachusetts General Hospital, Peter Bent Brigham Hospital, Boston, Mass.

Particular attention has been given to this phase of dietetics. Diseases best treated by high calory, salt-free diets, etc., are especially grouped to emphasize their importance. Methods of calculating these diets are also given.

Diets in general use today have been correlated in Practical Dietetics. It is not necessary to consult other references for these special and popular diets.

Over two hundred and thirty-eight thousand copies of Pattee's Practical Dietetics have been sold. It is revised almost annually, keeping pace with dietetic advancement. The National League of Nursing Education, the American Dietetic Association and all state boards of examiners of nurses recommend it as a text. It is the text adopted by the United States and Canadian armies, the United States navy, medical colleges, the leading hospital training schools and schools of household arts throughout the country.

AMERICAN ROENTGEN RAY SOCIETY

Among the forthcoming important meetings of special societies is the annual convention of the American Roentgen Ray Society. This is to be held in Chicago with headquarters at the Congress hotel, the time of the meeting being from September 18th to 21st. A number of eminent foreign contributors will appear on the program, and the announcements indicate that treatment by high voltage X-ray will have a prominent place on the program.

DR. W. S. SHIPP

On July 25th, Dr. W. S. Shipp made the supreme sacrifice and fell at the hands of a crazed drafted soldier, who had since 1918 nursed a fancied wrong. A silken flag, the gift of the General George Custer Post of the American Legion, draped his coffin, and the accompayning note expressed the sentiment, "The former service men of Battle Creek feel that Dr. Shipp paid the last full measure of devotion to his country, as much as though he had died on the battle field."

Dr. Shipp was born in Eckford township, Calhoun county, January 22, 1876, and after attending rural school there, entered the city school at Marshall. He finished his preparatory work at Albion College, where he attained quite a reputation as an athlete. In September, 1899, he entered the Medical School of the University of Michigan, where he received the degree of Doctor of Medicine in 1903. On June 28th, 1905 he married Miss Florence D. Temple of Tecumseh, Michigan. One son, Robert Temple Shipp, was born November 10, 1908.

Dr. Shipp had practiced medicine for 19 years and was past president of the Calhoun County Medical Society. For several years he was a member of the State Board of Registration in Medicine. He had endeared himself to all with whom he came in contact, so that few men were so universally beloved. He carried cheer into troubled homes, so that many a heavy burden was made lighter by his presence.

His cheery laugh is missed by all and he leaves vacant in the hearts of his many friends a place that can never be filled.